



NTSB National Transportation Safety Board

Aviation Industry Collaboration Success Story

Presentation to: NRC Committee on
Offshore Oil and Gas Safety Culture

Name: Christopher A. Hart

Date: October 8, 2014

The Win-Win

- **Conventional Wisdom:**

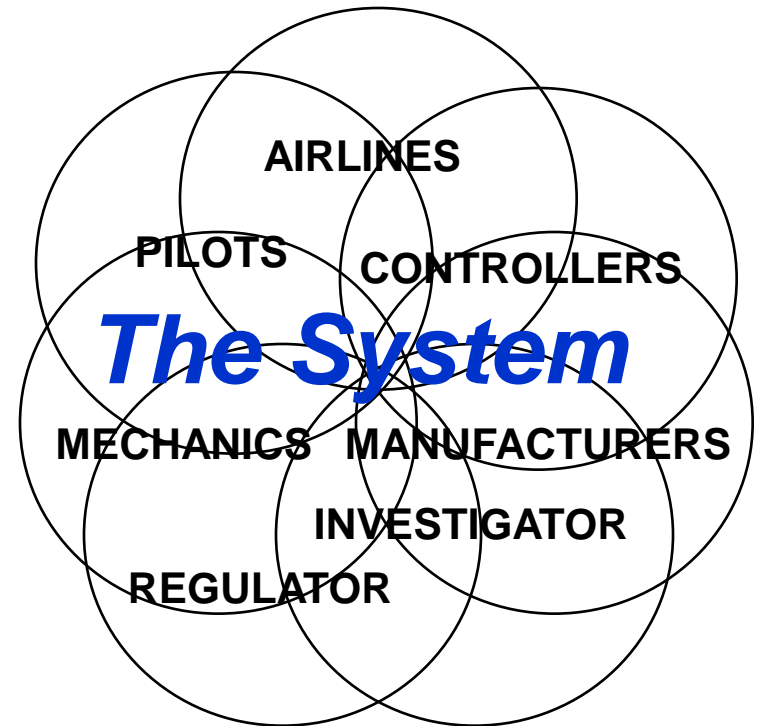
Improvements that reduce risk usually
also reduce productivity

- **Lesson Learned from
Proactive Aviation Safety Programs:**

Risk can be reduced in a way that also results in
immediate productivity improvements

The Context: Increasing Complexity

- **More System**
Interdependencies
 - Large, complex, interactive system
 - Often tightly coupled
 - Hi-tech components
 - Continuous innovation
 - Ongoing evolution
- **Safety Issues Are More Likely to Involve**
Interactions Between Parts of the System



Effects of Increasing Complexity:

More “Human Error” Because

- **System More Likely to be Error Prone**
- **Operators More Likely to Encounter Unanticipated Situations**
- **Operators More Likely to Encounter Situations in Which “By the Book” May Not Be Optimal (“workarounds”)**

The Result:

Front-Line Staff Who Are

- Highly Trained
- Competent
- Experienced,
- Trying to Do the Right Thing, and
- Proud of Doing It Well

. . . Yet They Still Commit

**Inadvertent
Human Errors**

When Things Go Wrong

How It Is Now . . .

You are highly trained

and

If you did as trained, you
would not make mistakes

so

You weren't careful
enough

so

You should be **PUNISHED!**

How It Should Be . . .

You are human

and

Humans make mistakes

so

Let's *also* explore why the
system allowed, or failed to
accommodate, your mistake

and

Let's **IMPROVE THE SYSTEM!**

Fix the Person or the System?

Is the **Person**
Clumsy?

Or Is the
Problem . . .

The *Step???*



Enhance Understanding of Person/System Interactions By:

- Collecting,**
 - Analyzing, and**
 - Sharing**
- # **Information**

Objectives:

Make the System

***(a) Less
Error Prone***

and

***(b) More
Error Tolerant***

The Health Care Industry

To Err Is Human:

Building a Safer Health System

“The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system.”

Institute of Medicine, Committee on Quality of Health Care in America, 1999

Major Source of Information: Hands-On “Front-Line” Employees

**“We Knew About
That Problem”**

***(and we knew it might hurt
someone sooner or later)***

Next Challenge



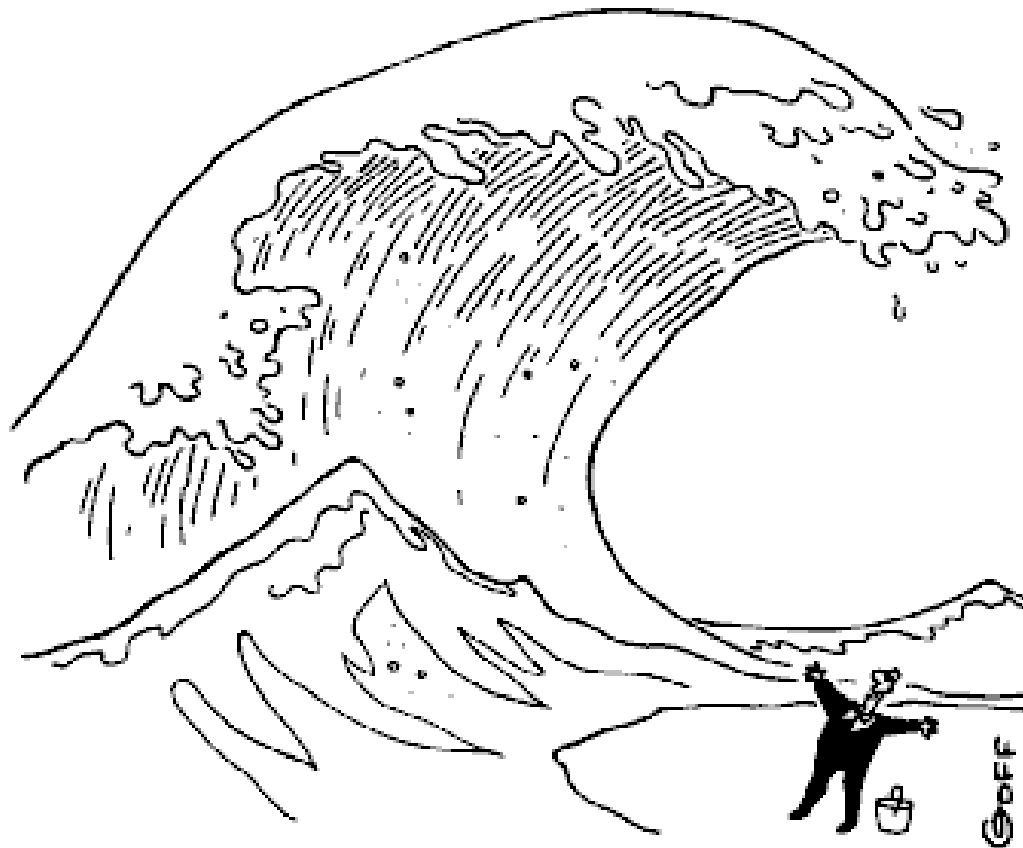
Legal/Cultural Issues

Improved Analytical Tools

As we begin to get over the first hurdle, we must start working on the next one . . .

Information Overload

© 1996 Ted Goff



"EUREKA! MORE INFORMATION!"

From Data to Information

Tools and processes to convert large quantities of data into useful information

Data Sources

Info from front line staff and other sources

DATA



Analysts

USEFUL

INFORMATION

Smart Decisions

- Identify issues
- **PRIORITIZE!!!**
- Develop solutions
- Evaluate interventions

Tools

Processes



Aviation Success Story

83% Decrease in Fatal Accident Rate,
1997 - 2007

largely because of
System Think

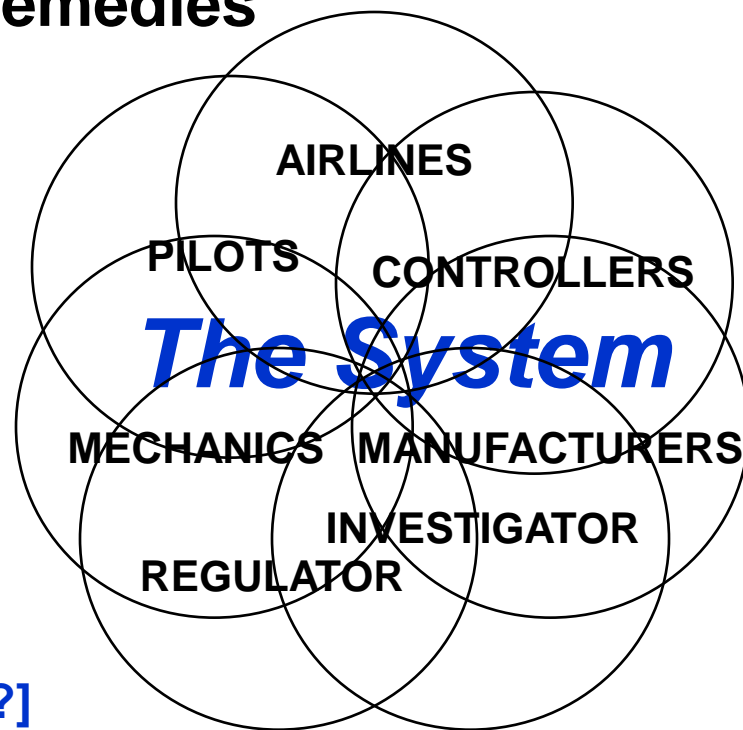
fueled by
***Proactive Safety
Information Programs***

P.S. Aviation was already considered **VERY SAFE** in 1997!!

Aviation “System Think” Success

Engage All Participants In Identifying Problems and Developing and Evaluating Remedies

- Airlines
- Manufacturers
 - *With the systemwide effort*
 - *With their own end users*
- Air Traffic Organizations
- Labor
 - *Pilots*
 - *Mechanics*
 - *Air traffic controllers*
- Regulator(s) [\[Query: Investigator\(s\)?\]](#)



Major Paradigm Shift

- **Old: The regulator identifies a problem, develops solutions**
 - Industry skeptical of regulator's understanding of the problem
 - Industry fights regulator's solution and/or implements it begrudgingly

- **New: Collaborative “System Think”**
 - Industry involved in identifying problem
 - Industry “buy-in” re interventions because everyone had input, everyone's interests considered
 - Prompt and willing implementation
 - Interventions evaluated . . . *and tweaked as needed*
 - Solutions probably more effective and efficient
 - Unintended consequences much less likely

Challenges of Collaboration

- Human nature: “I’m doing great . . . *the problem is everyone else*”
- Participants may have competing interests, e.g.,
 - Labor/management issues
 - May be potential co-defendants
- Regulator probably not welcome
- Not a democracy
 - Regulator must regulate
- Requires all to be willing, *in their enlightened self-interest*, to leave their “comfort zone” and think of the System

The Role of Leadership

- Demonstrate Safety Commitment . . .

But Acknowledge That Mistakes Will Happen

- Include “Us” (e.g., System) Issues,

Not Just “You” (e.g., Training) Issues

- **Make Safety a Middle Management Metric**

- Engage Labor Early

- Include the **System** --

Manufacturers, Operators, Regulator(s), and Others

- Encourage and Facilitate Reporting

- Provide **Feedback**

- Provide Adequate **Resources**

- **Follow Through** With Action

How The Regulator Can Help

- Emphasize the importance of System issues *in addition to* (not instead of) worker issues
 - Encourage and participate in industry-wide “System Think”
- Facilitate collection and analysis of information
 - Clarify and announce *policies for protecting information and those who provide it*
 - Encourage other industry participants to do the same
- Recognize that *compliance* is very important, but the *mission is reducing systemic risk*

Thank You!!!



Questions?